Medical Direction and Practice Board
21-November-2007
Minutes

In Attendance Members: Matt Sholl, Steve Diaz, Norm Dinerman (for Paul Liebow), David Ettinger, Tony Bock, Kevin Kendall, Jay Reynolds

In Attendance Staff: Jay Bradshaw

In Attendance Guests: Rick Petrie (Operations Rep and Ed Rep), Tom Judge, Lori Metayer, Ginny Brockway, Jeff Regis, Elizabeth Andrada, John Brady, Doris Laslie, Warren Waltz, Josh Dickson

Topic	**Discussion**	**Action(s)**
1) Introductions	None	None
2) Minutes from October 2007	None	Motion to Accept by Sholl, second by Ettinger, with unanimous approval
3) Legislative and Budget Update	No Update	None
4) EMS Education Agenda for the Future	The site is the following: http://www.nemses.org/ Jay summarized the project which is trying to standardize license levels across the country. It is currently in draft 2.0 and is available at the NHTSA web site. The 4 levels are Emergency Medical Responder, EMT-Basic, Intermediate (will actually be Advanced EMT), and Paramedic.	None
5) ALS definition in protocols	Some confusion arises because we have various levels of EMS licensure and response and attempt to capture with two types of umbrella terms, BLS and ALS. The tiered response necessary is not only amongst basic EMT and all others, but even amongst the Intermediate level and how it relates to the Critical Care/Paramedic levels. The question is can an ALS response be an Intermediate response? Financially, Medicare does allow for intermediates to bill at the ALS rate. This does not, though, provide clarification around when a call can be adequately "teched" at the intermediate level versus the CC/paramedic level. Many felt we need clarification but obviously, not an easy solution. One solution is to move away from the terms Basic and Advanced Life Support, but these are firmly entrenched in our profession. Another solution would be an attempt to list those times when we would allow an intermediate as the primary response for ALS and examples of threshold for CC/paramedic back-up. This second solution would be voluminous and still incomplete most likely. The eloquent solution is a tiered response with layering	To a small work group for potential solutions.

	of care—and drafting such language may be prohibitive. A small group comprised of Norm Dinerman, Jay Bradshaw, Rick Petrie and Steve Diaz will attempt to draft a solution.	
6) MEPARS	Held over for January 2008	None
7) Immunization Program Update	The Board of MEMS adopted language circulated to this group which for this trial year is inclusive of working EMS personnel only	Will monitor this and keep track of lessons learned for future programming in this area
8) OLMC Update	Recorded Yesterday	Ongoing progress
9) MEMS QI Update	Ongoing discussion around Mental Health Transfers; looking at airway data December 2007	None
10) MEMS Ops Update	Conference call on Immunization Update and Protocol roll out.	Ongoing progress on all fronts
11) MEMS Education Update	Finalized Evaluation of 2008 Protocol Rollout and also working on accreditation	Ongoing progress on all fronts
12) Cyanokit	Presentation of Cyanokit protocol, which will be at the Critical Care/Paramedic level in the Yellow section	First by Ettinger, Second by Kendall, with unanimous approval
13) MEMS Trauma Protocol Update	Presentation by Kendall of both TAC recommendations. On current Green 3, add use of Tourniquet to Assessment #2. Second, to consider Quik Clot to hemorrhage protocol. Kendall et al will test Quik Clot at Peter Goth's lab after recommendation by TAC to do so and if successful, to bring to MDPB for protocol recommendation. This will be trialed December 14, 2007. Sholl brought up two issues: you need to get this material close to bleeding site, and proximal if possible, and second, this should be part of a hemorrhage control protocol (direct pressure, etc.)	Approval to add use of Tourniquet to list on Assessment #2 on Green 3 and will look for follow-up from Goth lab and if good results, to have Quik Clot as part of a hemorrhage control protocol.
14) LOM Update	Kevin Kendall presented LOM protocol update. Minor changes include hyperkalemia protocol, they discontinued use of chest tubes and do finger/needle decompression, they have streamlined use of lidocaine and etomidate, they do Cath lab activation for STEMI, they are facilitating (in transfer) neuroprotective hypothermia after cardiac arrest, use pelvic binders, have discontinued steroids in spinal cord injury, have ability for scalp stapling, have an IO device change, and allow for permissive hypotension in selected cases.	Positive consensus from MDPB for all these changes, and clarification on one slide regarding post-arrest hypothermia to be an inter-facility protocol and not field protocol.
15) Next Meeting December 19, 2007		